

<p style="text-align: center;">Idaho Medical Home Collaborative <u>Meeting Notes – April 22, 2015</u></p>
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Present: Scott Dunn (co-chair), Matt Wimmer, Becki Wallace, Melissa Carico, Heather Clark, Donna Colberg, Debbie Schreiner, April Dunham, Meg Hall, Tim Heinze, Linda Rowe, Susan Ault, Yvonne Ketchum, Kevin Rich, Fred Martin, Neva Santos, Richard Rainey, Cindy Brock, Tiffany Kinzler, Deena LaJoie, Brianne LaDesma, Jesus Blanco, Mary Sheridan

<u>Topic</u>	<u>Discussion</u>
Welcome and Agenda Review	Scott Dunn welcomed the group. The previous meeting notes were reviewed and accepted.
Clinic qualifying/readiness criteria	<p>Scott talked a little about the clinic qualifying/readiness criteria document and how this group should review each of the five sections separately. Ultimately, the plan is to use this document to forward onto the IHC the recommendation for the application process for clinics as they get ready to solicit applications.</p> <p>Meg explained that the document was prepared by the Idaho Medicaid Health Home team based on their experiences from the pilot in the past two years. In addition, information was obtained from Dr. Dunn as the lead for this group and Dr. Rich, who was the lead from the practice transformation workgroup. She wanted to point out, for members to the IHC, that this is high level qualifying criteria and process to consider and not a readiness assessment for the pilot. They do have a readiness assessment for the pilot that digs in a little deeper, whereas this doesn't get to that detail.</p> <p>#1. The intent and vision of clinics should be aligned with the SHIP goal to transform primary care providers across the state into the patient-centered medical home. She said that it is important for all clinic administration to be required to attend PCMH "in-service" and submit written statement of intent and vision for the SHIP selection committee review. Dr. Epperly has discussed having the clinics sign an attestation of their intent to participate and these go hand in hand.</p> <p>Meg explained that in their efforts to recruit in their last year for Health Homes, they have put together a very nice power point and they have received follow up calls from clinics saying that they are just in it for the money and that it's not worth all the work. That's not the vision of the stakeholders, payers or SHIP committee. There needs to be a process where the intent is understood. Secondly, a clinic should not be permitted to complete readiness assessment until PCMH "in-service" is held to ensure clear understanding of magnitude of effort to transform. What they learned from the pilot is that the face to face interaction of a qualified in-service committee should be important before the attestation occurs. They are recommending an</p>

	<p>in-service and then followed by an attestation to move from a volume to a value based system. The clinics intent and support to invest the resources needs to be understood and agreed upon.</p> <p>Yvonne commented on part A under the first measure regarding the “in-service”. She said that it is unlikely that a clinic will be able to pull everyone out for a whole day to attend, so there should be some kind of staging, perhaps webinars or some method by which the clinic can attend. To have all clinic personnel attend at the same time might not be feasible.</p> <p>Meg replied that this is probably a process question for the IHC. Their thoughts, based on their experience, when they say “in-service” they were envisioning, whether it is a PCMH consultant or SHIP project team, actually going into the clinic and having a face to face visit with each clinic to share that information.</p> <p>Yvonne asked that if a clinic is already NCQA level 3, do we need to consider that if they apply, should any of these measures be waived, because they have already shown that their intent is to be a patient centered medical home? She wants the committee to consider that if the clinic is already a patient centered medical home and have received accreditation would the work be necessary.</p> <p>Meg said that it absolutely needs to be considered. She said that they are handing over a lot of accredited clinics and they do need to look at this in the sense of a new SHIP clinic. She does feel that the process needs to be customized if they are already recognized. Scott said that maybe we could add some language under part B that allowance would be made for already recognized clinics to have a shorter readiness assessment.</p> <p>Meg said that she thinks there is still value participating in the SHIP. Going forward is a little bit different than where they came from, so there may still be value but it will looks different. She will add the language to the document.</p> <p>Scott said that we may want to add language to consider that the “in-service” should be on-site because that would be easier for the clinics. He asked “are we suggesting that the “in-service” needs to be done before they apply or that they have to agree that if they apply and are accepted they would need to have an “in-service” after the application but before they start the project.</p> <p>Kevin Rich commented in the pilot that one of the things that was intended with the pilot to have those practices be in of themselves technical support. The practice coaches really hadn’t practiced in clinics and they were Medicaid employees and so they hadn’t practiced in clinics where transformation had actually happened. They hadn’t gone thru the process. There was real value in being able to have the ability to reach out to the practices that had already gone thru the process to be technical</p>
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	<p>support and sharing real life experiences with practices that are going thru it. One of the things that we may want to clarify to the practices or ask the practices who are already NCQA recognized “would you be willing as part of the SHIP to be a resource for those practices that are beginning the process”. He suggests that maybe this could be a part of their “in-service”.</p> <p>Meg commented that we want to keep in mind, with the development and implementation of the regional collaborative that they will also serve as that focal point to be the repository for best practices and connect clinics to share workflows, IT and EMR. She said that they do have the intent that recognized clinics would serve as mentors.</p> <p>#2. Physician leadership champion, clinic administration engagement and a dedicated transformation team is imperative for successful transformation and sustainability. A solid physician engagement strategy lays the foundation for current and long term change. Meg said she is hopeful that clinics will be able to identify who their physician leadership is. The office manager plays a very imperative roll especially if you’re looking at changing workflows and turning upside down daily operations. If possible it’s important for the clinic early on at point of attestation to be available to identify their PCMH change agent or who their project lead will be. In their experience, in many instances the PCMH change agent will wear many hats. If possible in the recruiting and qualifying criteria a clinic needs to be thinking about the designation and cooperation of those three key players.</p> <p>Mary asked Meg to clarify a little what the vision is for the required face to face SHIP team meeting. Is it the vision that the SHIP team will go out to the clinics or will it be done remotely?</p> <p>Meg replied that they are not involved in the decision making for the formula, the roles or the players. But for example, be it the SHIP team or the PCMH consultant, once all of that is determined, maybe it will be the PCMH consultant. It made sense that they would have a standard curriculum that they would meet with clinic administration and these other identified individuals at the part of the “in-service” to fully understand what the participation and the goals are. The process has not been developed yet, but is likely that it would be a follow-up, not necessarily in person, and that the clinic as a part of application would be able to identify the physician leadership, clinic administration and dedicated consultant and that would be part of the attestation.</p> <p>Mary said that what her vision and what she would support is that there would be a team, going on-site to the clinic. She hopes that the expectation wasn’t that the clinic champion and staff would be coming to Boise to meet everyone.</p> <p>Meg replied no not at all. The value of a round table communication discussion amongst the players of the clinic is where the value will be.</p>
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Scott said to further clarify the purpose of the in-service under part A and differentiate the in-service under part B, maybe just spelling out a little more of the timeline to when that would occur in the application or attestation process. Initial step one information in-service probably could be remote as clinics are gearing up for making an application. Step two makes sense to have the face to face to have the commitment.

Meg said that the remote video conference or webinar still allows for exchange. This is unfolding as we speak and she indicated she would modify the document accordingly.

#3. Adequate clinic resources are essential to transform to the PCMH model. **Meg** said that this is a little along the same lines as before. Is the information clear enough, does the clinic understand and does it have adequate resources to move forward? What they learned is that it would be important for the clinic to be able to submit to the selection committee a proposed operational plan on how they plan to move forward and transform over the coming four years. In that operational plan would be a budget, practice type and size, current staff structure, staff resources dedicated to the transformation plan, the timeline to achieve PCMH recognition and any other PCMH initiatives clinics are participating in. A lot of this education and disclosure is for the clinic to look at their feasibility and move forward. Budget is very important and equally challenging. Their thought is that it would be the role of PCMH consultant or committee to have a template and a starting point to assist the clinic in preparing a budget. This is fact finding and discovery for both the clinic and the SHIP committee to determine the readiness of the clinic based on the operational plan they submitted.

Scott added that this is not just a budget for expected expenses for the clinic, but also revenue. The clinic should be able to sketch out an estimate of their revenue to balance their expenses. In lessons learned under 3 and 4, part of the challenge is having that revenue piece transparent early enough in the process so they can have a reasonable idea of how that is going to play out. This is where the payer roles are really key in having that available, somehow of estimating for the clinics what their revenue will be. He would like to have the payers comment on this.

Becki said she said that it is a reasonable expectation in that they would need an estimate from payers in what patients would be included in any program that they put together. At this juncture, they haven't formalized a program yet and they are still discussing several different scenarios.

Scott asked Becki "if a clinic in September is considering applying for the first wave and is trying to put together their budget, could they request that Blue Cross look at their practice, run the numbers and give them an estimate of their revenue?"

	<p>Becki replied yes, they do have the ability to identify their current patients under their current program as well as any alteration to that program, so they could see by volume which patients would qualify. If they move forward with a PMPM arrangement as we have now in place, then they would be able to give them an estimate</p> <p>Scott feels that this would be very valuable and helpful to clinics who are going into the process with their eyes wide open, knowing their expenses and revenue changes.</p> <p>Becki commented that in addition to continuing with the PMPM, Blue Cross is considering some other alternative financial pieces such as a different fee schedule for the PCMH with a withhold of some kind. There are several different scenarios that they are discussing and she is hopeful that they will have come to a decision within the next couple of months in what direction they will go.</p> <p>Matt commented that Medicaid is in the process on their plans for a tiered system that would support practices thru a PMPM amount in addition to the fee for service model that would support practices that are in the earlier stages of moving toward primary care medical home transformation. Medicaid would definitely be able to provide something that would allow practices to estimate their additional revenue that they may be able to tap into. Some of this is yet to be decided as Medicaid will be going thru negotiated rule making thru the summer.</p> <p>Scott suggested that what should be included under this section of the budget is that they are looking at this as both an expense and revenue estimate. The recommendation is that the payers be available to help clinics with the estimate.</p> <p>Mary commented that she thinks that one key for success in this initiative will be the development of a template that all of the clinics can use.</p> <p>#4. Adequate and effective HIT capabilities are critical to support the PCMH model. Meg spoke about section A and explained that she wasn't involved at the initiation of the pilot, but knows that there was a lot of discussion with the SHIP and the decision was never made if an EMR is required. This is where the education will be important of understanding what it takes to move to this highly coordinated model.</p> <p>Matt said that so much of being a primary care medical home model is coordinating all of the information. It is a little tricky and a very challenging part for any organization</p> <p>Meg said that in their experience over the past two years, many of their health homes and pilot clinics are connected to the</p>
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IHDE, but they are not using the functionality or at this time they are challenged with using that functionality. We need to try to align and consider other initiatives across practices to use some of the same baseline so that clinics are not asked to jump thru completely different hoops to meet the same outcome. Meg had the opportunity to work with four clinics last week as they work thru the challenges of care plans, based on the obstacles of their EMR. This continues to be an issue and needs to be supported.

#5. Evidence of QI activities or defined plans for QI structured activities is critical to implementing and sustaining the PCMH model. Meg said that in order for clinics to transform and make these changes last there has to be a fairly sophisticated QI process to identify the need for workflow changes or the sustainability of workflow changes. Their recommendation from the pilot experience is that the clinics either have an integrated QI process or the PCMH consultant will help to implement one.

Scott added that A and B are similar, but for clinics who don't have a QI process yet, maybe we should add that a clinic be able to outline their plan for QI or their vision of QI, to give the committee that is reviewing some idea of what they will be doing even if they are not doing it currently.

Kevin said this is the reason why this was used as our first webinar of the pilot. It was to teach the clinics what a QI process is and what a PSDA cycle is. He said that this isn't something that is taught in medical school and many small practices may not know what a QI process is. You can't transform without some kind of QI process.

Mary says she agrees. She would like to see this framed in a way that we can really get those clinics on board that are engaged, but don't have formal QI processes. She doesn't want this to appear as if they would be excluded.

Yvonne added that as you mirror up their willingness, it might be nice to have something in here as to how the SHIP grant is going to help them achieve these standards so it doesn't seem like such a huge task.

Meg replied that she agrees. This is certainly something that should be in their information packet, so it is something well known up front. The magnitude of the effort needs to be explained, but it also needs to be real clear what the SHIP support will look like because that will all be necessary information to make a business plan.

Tim Heinze commented that it is great to be as clear as we can on the expectations, responsibilities and roles but we also need to keep in mind that with any initiatives or project like this that is over an extended period of time, there will be clinics that don't succeed and we can't prevent that from happening.

	<p>Scott said that the message they were hoping that the IHC will be giving to the clinics is that they are there to help. The IHC will do everything they can to help clinics succeed and hopefully the vast majority will even it's not 100%.</p>
TransforMed Update	<p>Matt said that Dr. Kohl came out to Coeur d'Alene to meet with department staff and Dr. Dunn. Dr. Kohl gave a quick overview of their final report and some of the things that they are looking at. Matt said the report looks very promising and all the work that everyone has put into transforming to a patient centered medical home has really paid off. He thinks that it is very positive and confirmed that Dr. Kohl will have the final report within the next couple of weeks.</p> <p>Scott commented that Dr. Kohl asked if there was anything else specific that we wanted to look at in the report. Scott then asked members in the meeting if there is anything else that should be added to the final report.</p> <p>It was asked if there is a list of items that will be in the report and Matt replied that he has sent a copy of the contract out to the collaborative which summarizes the work that TransforMed is accomplishing.</p> <p>Matt said he would send out the scope of work sections that are relevant out to the collaborative.</p> <p>There was some discussion regarding Dr. Kohl's presentation and having him travel to Boise to give his presentation in person.</p>
First Quarter "Extended" Pilot Update	<p>Regence - Brianna spoke about next month's Idaho Care Coordinator Academy that is open to any care coordinators. This opportunity is to learn some basic and advanced topics in care coordination like shared decision making and motivational interviewing. Care coordinators at the academy will be able to share best practices and participate in networking. On-line registration is available and the link will be sent out. The Academy is scheduled for May 12th and 13th at the Red Lion in Lewiston.</p> <p>Blue Cross - Becki said they have about 915 eligible members now. They haven't seen much change.</p> <p>Medicaid – Donna Colberg reported they have 30 active pilot clinics and of that 23 are recognized. They have four that need to meet the 2011 deadline and they are awaiting their notice. One is on an extension for their recognition and two that will end up withdrawing. For the overall Health Home program, 50 that are active, 41 are either recognized or have an application out. Clinics continue with clinical data and reporting submission and they are focusing on care plan compliance. Enrollment numbers are down, 8672 enrolled, which is down by 289 in March, but this was anticipated with the care plan audit that occurred recently.</p>

	Meg announced that Heather Clark moved to the SHIP project team and her Quality Improvement practice coach position has been posted for the Boise area.
Next Meeting	The next meeting will be a face to face meeting, Wednesday, June 24 th from 1:30 to 5:00.